Benefit Summary

# City Of Seattle Local 77
# Group Number: 0471500 / 4471500

GroupHealth.

| **Effective Date** 1/1/2011 | **Health Plan** Group Health | **Ref** RQ-39078 |
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This is a brief summary of benefits. THIS IS NOT A CONTRACT OR CERTIFICATE OF COVERAGE. All benefit descriptions, including alternative care, are for medically necessary services. The Member will be charged the lesser of the cost share for the covered service or the actual charge for that service. For full coverage provisions, including limitations, please refer to your certificate of coverage.

In accordance with the Patient Protection and Affordable Care Act of 2010,

- The lifetime maximum on the dollar value of covered essential health benefits no longer applies. Members whose coverage ended by reason of reaching a lifetime limit under this plan are eligible to enroll in this plan, and
- Dependent children who are under the age of twenty-six (26) are eligible to enroll in this plan.

Group Health believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act of 2010. Questions regarding this status may be directed to Customer Service (888) 901-4636. You may also contact the Employee Benefits Security Administration, U.S.Department of Labor at (866) 444-3272 or http://www.dol.gov/ebsa/healthreform.

| **Benefits** | **Inside Network** |
|---|---|
| **Plan deductible** | No annual deductible |
| **Individual deductible carryover** | Not applicable |
| **Plan coinsurance** | No plan coinsurance |
| **Out-of-pocket limit** | Individual out-of-pocket limit: $750<br>Family out-of-pocket limit: 2 |
| **Pre-existing condition** (PEC) **waiting period** | No PEC |
| **Lifetime maximum** | Unlimited |
| **Outpatient services** (Office visits) | $5 copay |
| **Hospital services** | **Inpatient services:** Covered in full<br>**Outpatient surgery:** $5 copay |
| **Prescription drugs** (some injectable drugs may be covered under Outpatient services) | Formulary generic and/or brand<br>$5 copay |
| **Prescription mail order** | 3 x prescription cost share per 90 day supply |
| **Acupuncture** | Self-referred up to 8 visits per medical diagnosis per calendar year; additional visits when approved by the plan<br>$5 copay |
| **Ambulance services** | Plan pays 80%, you pay 20% |
| **Chemical dependency** | **Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Devices, equipment and supplies**<br>• Durable medical equipment<br>• Orthopedic appliances<br>• Post-mastectomy bras limited to two (2) every six (6) months | Covered at 80% |
| • Ostomy supplies<br>• Prosthetic devices | Covered at 80% |
| **Diabetic supplies** | Insulin, needles, syringes and lancets-see Prescription drugs. External insulin pumps, blood glucose monitors, testing reagents and supplies-see Devices, equipment and supplies. When Devices, equipment and supplies or Prescription drugs are covered and have benefit limits, diabetic supplies are not subject to these limits. |

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| **Diagnostic lab and X-ray services** | **Inpatient:** Covered under Hospital services<br>**Outpatient:** Covered in full<br><br>High end radiology imaging services such as CT, MR and PET must be determined Medically Necessary and require preauthorization except when associated with Emergency care or inpatient services. |
| **Emergency services** (copay waived if admitted) | $50 copay at a designated facility<br>$100 copay at a non designated facility |
| **Hearing exams (routine)** | $5 copay |
| **Hearing hardware** | Not covered |
| **Home health services** | Covered in full. No visit limit. |
| **Hospice services** | Covered in full |
| **Infertility services** | Not covered |
| **Manipulative therapy** | Self-referred up to 10 visits per calendar year<br>$5 copay |
| **Massage services** | See Rehabilitation services |
| **Maternity services** | **Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Mental Health** | **Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Naturopathy** | Self-referred up to 3 visits per medical diagnosis per calendar year; additional visits when approved by plan<br>$5 copay |
| **Obesity-related surgery (bariatric)** | Covered at cost shares when medical criteria is met |
| **Organ transplants** Donor search & harvest applies to lifetime max | Unlimited, no waiting period<br><br>**Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Preventive care** Well-care physicals, immunizations, Pap smear exams, mammograms | Covered in full |
| **Rehabilitation services** (Occupational, speech, physical including services for neurodevelopmentally disabled children age six and under)<br>Rehabilitation visits are a total of combined therapy visits per calendar year | **Inpatient:** 60 days per calendar year<br>Covered in full<br>**Outpatient:**60 visits per calendar year<br>$5 copay |
| **Skilled nursing facility** | Covered in full up to 60 days per calendar year |
| **Sterilization** (vasectomy, tubal ligation) | **Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Temporomandibular Joint** (TMJ) **services** | $1,000 per calendar year; $5,000 lifetime max<br><br>**Inpatient:** Covered in full<br>**Outpatient:** $5 copay |
| **Tobacco cessation** See pharmacy benefit for associated drug coverage | Covered in full |
| **Routine vision care** (1 visit every 12 months) | $5 copay |
| **Optical hardware** Lenses, including contact lenses and frames | Not covered |